Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
ASCENDANT ANESTHESIA
25 HIGHLAND PARK VILLAGE SUITE 100-775
DALLAS TX 75205-2726

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-11-2668-01

MFDR Date Received
APRIL 5, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 64447 was denied stating 'payment included in the allowance for another service/procedure.' I sent a reconsideration to the carrier stating that two different providers performed the services billed. Each procedure performed is to be reimbursed separately."

Amount in Dispute: $126.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2010	CPT Code 64447	$126.33	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-Payment is included in the allowance for another service/procedure.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent reduced the payment for CPT code 64447 based upon reason code "97."

   On the disputed date of service the requestor billed CPT codes "01400-QZ-Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified, and 64447-Injection, anesthetic agent; femoral nerve, single".

   The requestor states in the request for reconsideration that "This procedure was performed by a different provider than the anesthesia, and is to be reimbursed separately. I have attached another copy of the anesthesia record and the Regional Anesthesia Procedure form for this patient and date of service, please note that Aaron Lahasky, CRNA provided anesthesia and David Pettett, M.D. did the pain block procedure. Both providers are members of the Ascendant Anesthesia group, but their services are to be reimbursed separately."

   According to NCCI edits, CPT code 64447 is a component of code 01400. A modifier is allowed to differentiate the service. A review of the medical bill finds that the requestor did not utilize a modifier.

   In addition, the 2010 National Correct Coding Initiatives Manual states "CPT codes 64400-64530 (Nerve blocks) may be reported on the date of surgery if performed for postoperative pain management rather than as the means for providing the regional block of the surgical procedure…Modifier 59 may be reported to indicate that the injection was performed for postoperative pain management, and a procedure note should be included in the medical record."

   According to the Regional Anesthesia Procedure report "It was agreed that the peripheral nerve block would be performed..before procedure." Therefore, the documentation does not support that the nerve block was for postoperative pain management and should not have been billed separately. Asa result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/21/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.